

PERSONAL DETAILS

Surname: _____ Given Names: _____

Address: _____

_____ Postcode: _____

Telephone No: (Home) _____ (Bus): _____

Mobile No: _____ Date Of Birth _____ Age _____

Email: _____

Health Insurance Fund: _____ Membership No: _____

Medicare Number: _____ No. on Card: _____ Exp: _____

Veteran Affairs: _____ Exp: _____

Pension Card: _____ Exp: _____

NEXT OF KIN (mandatory)

Name: _____ Relationship: _____

Telephone No: _____

REFERRAL DETAILS

It is very important that your GP and Specialist doctors are informed of your weight loss especially if you are taking medication for any related problems. Please inform the clinic of all your doctors.

GP Details: : _____

Address: _____ Phone: _____

Specialist Doctors: _____

HOW DID YOU HEAR ABOUT EASTERN OBESITY CLINIC?

Newspaper Magazine/Courier Website General Practitioner

Family/Friend _____ Other _____

<u>Office Use only</u>	Wt (kg)	Ht (m)	BMI
	IBW	XS	
	$IBW = Ht^2 * 25$	$XS = Wt - IBW$	

WEIGHT HISTORY

What is your current weight? _____ **maximum weight?** _____

Cause Of Xs Weight/Food weakness (circle): Familial Excess-Food Wrong Food
 Snacking Alcohol/Liquids Pregnancy-Related Other
 Causes _____

What's Been Tried? Jenny Craig Weight Watchers Sureslim Optifast
 Acupuncture Hypnotherapy Duromine Xenical Reductil Fads/ Diet'
 Other _____

How seriously have you tried these measures? (circle):

very, moderately, half-hearted

Most amount of weight loss _____ **How long maintained** _____ (months)

Why do you feel it didn't work?: _____

Exercise At Present Time:

How long have you been thinking about weight loss surgery / balloon?

What research have you done? (circle); info night, know someone who has had the procedure, internet, brochure, consult with obesity surgery staff, other _____

Do you feel you have a reasonable knowledge of the following procedures (circle);

Gastric balloon, Laparoscopic Gastric Band, or Laparoscopic Sleeve (tube) Gastrectomy

Do you have support from (please circle); family, partner, local doctor, specialist, friend, other

(list) _____

What is your motivation (circle); energy level, short or long term health, appearance,

self esteem, fear of premature death, comorbid disease control, comorbid disease prevention, social isolation, mobility, other (list)

PERSONAL MEDICAL HISTORY

Are you planning to get pregnant soon? Details: _

Have you ever suffered with any of the following health problems:

Diabetes (if so-how long)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Diabetes while pregnant	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Asthma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Respiratory/Breathing problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Arthritis/ joint pain / joint surgery	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
High blood pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Heart disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
High cholesterol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Reflux or heartburn	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____

Please list all allergies,including drugs, dressing or food.

Please give details of any major illnesses/problems:_____

Please list all past operations

Do you take any regular medications?(please list strength and frequency)

Please list all vitamins and supplements you take

ALCOHOL:

Do you drink alcohol? Never Rarely Regularly

How many standard glasses do you drink per day/week? _____

SMOKING:

Do you smoke? Yes No Never If yes: how many per day? _____

Have you smoked in the past? Yes No If so, how many per day?

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING / CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring/sleep apnea					
Asthma					
High Cholesterol					
Osteoporosis					
Hip fractures					